

**HOSPICE OF SANTA CRUZ COUNTY  
ATTENDING PHYSICIAN CERTIFICATION**

To: \_\_\_\_\_ Fax: \_\_\_\_\_ Phone: \_\_\_\_\_

From: ADMISSION DEPT Fax: 831-430-9271 Phone: 831-430-3093

Patient Name: \_\_\_\_\_ Terminal Dx: **Liver Disease** Date: \_\_\_\_\_

The above named patient/family has expressed interest in Hospice services. Medicare guidelines require documentation of prognostic data. The prompts below are intended to make the process as convenient as possible. Thank you.

Patient with:

Prothrombin time prolonged more than 5 sec. over control, or INR > 1.5 & Serum albumin < 2.5 gm/dl.

**AND**

At least **one** of the following:

- Ascities, refractory to treatment or patient non-compliant
- Spontaneous bacterial peritonitis
- Hepatorenal syndrome (elevated creatinine and BUN with oliguria (< 400 ml/day) and urine sodium concentration < 10 mEq/l.
- Hepatic encephalopathy, refractory to treatment or patient non-compliant
- Recurrent variceal bleeding, despite intensive therapy

**Supporting Evidence**

- progressive malnutrition
- muscle wasting with reduced strength and endurance
- continued alcoholism (> 80 gm ethanol/day)
- hepatocellular carcinoma
- HBsAg (Hepatitis B) positivity
- Hepatitis C refractory to interferon

	Yes	No
I support hospice care at this time.	<input type="checkbox"/>	<input type="checkbox"/>
I will be pt's attending physician.	<input type="checkbox"/>	<input type="checkbox"/>
I have discussed px with patient/family.	<input type="checkbox"/>	<input type="checkbox"/>
I will sign the death certificate.	<input type="checkbox"/>	<input type="checkbox"/>

Based on the information indicated above, the above named patient has a medical prognosis that life expectancy is 6 months or less, if the terminal illness runs its normal course.

Telephone Order by \_\_\_\_\_ Date \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_